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PROBLEM RESOLUTION

Never assume the obvious is true.

—William Safire

If you can't fix the problem, change the problem.

—J. R. Freeman

Consider the following list of interventions. Each describes an example of sound, evidence-based practice; yet each is relatively counterintuitive.

- A therapist, working with a client who has panic attacks, asks her client to bring on panic during the session.
- Another therapist, working with someone who has been recurrently depressed, teaches his client to allow depressing thoughts to pass through her mind without needing to respond to those thoughts.
- Still another therapist asks a quarreling couple to pick a fight with one another when they are not mad.
- A sex therapist prohibits a couple from having intercourse despite prescribing arousing exercises.
- Another client is told that there may be good reasons not to change.
- A parent, needing to regain control of her child's behavior, is taught to take charge by not directly taking charge.
- Another therapist tells his client that he can't blame her for wanting to harm herself when she becomes emotionally frustrated. He then asks her to experience more emotional frustration while considering other ways to react to it.

In the last chapter, we described how clients' problems are most often the result of attempts to create stability through first-order change. In fact, virtually all problems brought to psychotherapy can be understood as the result of vicious cycles that are initiated and maintained by well-intentioned first-order solutions; that is, these first-order change processes unintentionally stabilize, and typically worsen, the undesirable condition. Therefore, effective therapeutic interventions are targeted as changing solution patterns. Each intervention is an example of effective psychotherapy. Each approach is well supported by research. Each therapist understands his or her intervention within his or her chosen theoretical framework. Yet all of these interventions appear to be ironic and counterintuitive. The objective of this chapter is to show that this shared irony points to a powerful unifying framework that is at the heart of all effective psychotherapies. It is the ground of change from which all of them grow. It is the golden thread of second-order change that runs through the fabric of all of them.

Clients are changing, and yet not in the ways they desire. In the last chapter, we drove home the point that problems are most often a product of first-order folly—that is, virtually all problems brought to psychotherapy can be understood as vicious cycles that are initiated and driven by well-intentioned, failed solutions. In a strange way, the attempt to restore a desired state of stability escalates the problem pattern. We find ourselves in a contradictory situation in which the problem-producing process unintentionally stabilizes the undesirable condition. In other words, the more we attempt to resolve the problem, the more stable the problem becomes. Therefore, effective interventions are targeted as changing solution patterns. The essence of problem resolution is a shift in the pattern of failed solutions. Even the term *resolution* may be thought of in this sense as a “re-solution,” or the introduction of alternate solutions to the problem at hand. At the most fundamental level this is second-order change, the focus of this chapter. We argue that second-order change is the catalyst for problem resolution that runs through all effective psychotherapies.

WHEN FIRST-ORDER SOLUTIONS SUFFICE

There are several key differences that distinguish the type of psychotherapy that occurs in clinical trials from psychotherapy in the field. A critical difference from the perspective of first- and second-order change pertains to client selection. Empirically supported treatments (ESTs) are designed for clinical conditions that have evolved to a degree of severity that second-order change will almost always be necessary. Clients are chosen to participate in a clinical trial because they have a problem that meets specific problem severity criteria. Psychotherapy in the “real world” of clinical practice has become highly popularized in Western culture. Clients may seek advice

before a vicious cycle has actually begun to unfold. In such situations, direct advice or suggestions may be the most effective approach.

For a therapist to attempt a second-order intervention when a first-order one will suffice is for the therapist to fall into one of the three options for initiating or perpetuating problems noted in the last chapter—that is, making a simple problem more complex or intervening at the wrong level. Sometimes, simply reinforcing consistency in already-existing solutions, re-engaging clients in their own tried-and-true solutions, adding a new variation on a current set of solutions, or slightly redirecting a current set of solutions is all that is needed. A parent who has been inconsistent in offering rewards or consequences may experience success with his child by simply rewarding the child more frequently or applying consequences in a more consistent fashion. A woman who has always resolved life difficulties through sharing with her sister may be helped to reengage with her sister for some sisterly support. Noting clients' strengths and skills, refining those skills, or directing them in a slightly new path are other examples of what are, in essence, first-order level interventions by therapists. Experienced therapists will remember that many clients have been helped when they reassured them that they, in fact, aren't crazy or actually are headed in the right direction. (The bicycle rider or the tightrope walker we mentioned in the last chapter may need only to be reminded about over- or undercorrecting to maintain his balance and his course.) Effectively assisting clients with engaging in or refining first-order solutions requires that they are involved in the treatment and compliant with the therapist's suggestions. This is the essence of the working alliance and positive trusting relationship we discussed in chapter 1 of this volume. Such compliance is sometimes simple, direct, and forthcoming. If it is not, another type of vicious cycle may ensue. This involves a cycle within the therapeutic relationship in which the therapist gives advice and the client does not follow it. When this occurs, a second-order intervention is needed at the therapeutic alliance level. We discuss this further in the next chapter. In sum, second-order change should never be attempted when first-order change will suffice. This is a rule for both clients and therapists.

WHEN FIRST-ORDER CHANGE IS NEEDED

For the most part, clients enter therapy with strongly entrenched problems that are vicious cycles of first-order solutions. A key element in effective psychotherapy is the initiation of second-order change. It will help to revisit the definition of second-order change, pick it apart some more, and offer a few more simple examples and experiences with it before turning to how effective psychotherapists bring it about.

Recall how we defined *second-order change*: a change of a group or system's primary premises and related rules and interaction patterns. It is, in essence, a change of the change process itself. Changing the change process is a de-

ceptively simple proposition; however, because the logic involved in problem generation is compelling, it is easy to produce apparently new solutions that turn out to be more of the same old solutions. The previously mentioned parent struggling with an oppositional child may come up with a novel reward. If rewards have repeatedly failed, a more novel one will only perpetuate the cycle. Second-order change usually involves strikingly different or opposite interactions. It is the difference between the new novel solution and what has been tried before that transforms the group or system. Such change also appears illogical or counterintuitive when viewed from within the original premises and rules of the system in question. This is a function of how logical systems operate. Logical systems establish parameters that define what makes sense in problem solving. Solutions that are within the parameters of a given logical system "feel right." Solutions that are outside of the system are experienced as strange, unusual, counterintuitive, ironic, or even forbidden. For that parent who is trying to gain control of an oppositional child, a second-order solution may entail a way of interacting that avoids rewards or direct consequences. This will most likely make no sense within the context of a system that is predicated on such reinforcements.

THEORETICAL ROOTS

The implications of this view on change are extraordinary for the practice of psychotherapy. This perspective suggests that change operates on principles other than what has been described in the major theoretical frameworks that comprise the behavioral health field. Yet what is the basis for the operant principle that is at the heart of change? Without a psychological theory to describe the relationship between stability and change, theoreticians at the Mental Research Institute turned to theories of logic that are found in mathematics. When the terms *first-order change* and *second-order change* were first defined in the book *Change: Principles of Problem Formation and Problem Resolution* (hereafter we refer to this work as *Change*; Watzlawick et al., 1974), the authors used *set theory*, or *the theory of groups*, as the explanation for first-order change, and the *theory of logical types* as the rationale for second-order change. Although these theories serve as a sound foundation for understanding how change occurs, they are highly complex, rather abstract, and often confusing to follow. Because of the conceptual challenge of these theories, most people familiar with the work have overlooked or forgotten them. They are, nevertheless, firm foundations for understanding change, and they deserve attention.

GROUP THEORY

There are aspects of group theory and the theory of logical types that are important to the case that is being made for the golden thread. For the

purpose of our current discussion, we will describe these two theories very simply. Turning first to group theory, a group may comprise any kind of like members, from people to ideas. The theory of groups suggests that once a group is set, all interactions within the group, according to the assumptions and rules of the group, will maintain the group's identity. Thus, once set, all interactions preserve and perpetuate the stability of the group. There can be many changes in the interactions of the group and no change of the group will result. A group may not change itself from within. Groups are defined and bounded by their group definitions and related interaction rules. In applying this mathematical analogy to human dilemmas it does not mean that if the group contains people that people cannot change the group. It does mean that change cannot be initiated with the same assumptions and interactions that have initiated the problem. This is impossible from the perspective of formal logic. In other words, human folly is rooted in how a problem is understood. Understandings of problems are shaped by premises and assumptions on the way things are. Once problem-solving constructs have been set, escape is difficult, if not impossible. This simple definition may seem so obvious as to be confusing. Suffice it to say that the theory of groups underlies what has thus far been described and exemplified as first-order change, with all of its vicious cycles of solution-generated problems. As with most mathematical theory, the basic ideas are rather broad reaching and universal.

THE THEORY OF LOGICAL TYPES

Second-order change is based on the theory of logical types, which is closely related to group theory. As previously stated, group theory demonstrates the futility of attempting to initiate change with the same set of constructs that have initiated the problem. The theory of logical types shows how constructs from outside a group can be incorporated into a group, resulting in a change in the original group's identity. (The synonym for group in logical typing is the word *class*.) To make such a foundational change in any group, the very assumptions that define the group and its interactions must be changed. To accomplish this change, one must move to what is called a *higher level* or *class* of assumptions and definitions that subsume the original ones and describe and explain them as well or better. This kind of change is a basic shift in premise or mental set. From a dialectical perspective, this is the synthesis that integrates apparently opposing positions.

Consider, for example, a client who comes for therapy with anxiety about making mistakes in social situations. In this case, the client has a mental set that classifies all social mistakes as bad experiences without redeeming value. This understanding leads the client to place enormous pressure on himself to avoid social miscues. In social situations, he focuses exclusively on

his own behavior in an effort to perfect his socialization skills. Close self-scrutiny distorts his perception of himself in social situations, raises his anxiety, and increases the likelihood that he will make social miscues. This obviously paves the road to human folly. In this instance, a higher class of constructs might be a class that defines social mistakes as both bad experiences and necessary opportunities for social learning (also explained as an integration and affirmation of previously opposite poles under a new idea of how one gains social competence). The inclusion of "necessary social learning opportunities" into the set of bad experiences creates a novel classification: "bad experiences that have redeeming value." The new concept is similar to the old one because it recognizes social mistakes as bad experiences. At the same time, the idea of learning from mistakes can hardly be denied. The word *necessary* pushes the notion of the good in mistakes a step farther. This new twist on an old concept actually better describes how social leaning works. Once made, the shift opens multiple and cascading new options for action. In response to this new set of constructs, the client may become more self-tolerant or even begin looking forward to making social mistakes so that he can learn more quickly how to socialize with others. If he is daring, he might take this idea further yet and make small social miscues on purpose in an effort to learn socializing skills at a more profound level. Also, once the shift is made, it is very difficult to shift back. The subsequent actions based on the logical shift will be perfectly logical from within the premises of the new set, but they may appear impossible or certainly illogical from the prior set.

In *Change* (Watzlawick et al., 1974), the authors wrote about "terrible simplifications." The idea of levels in problem solving can be understood as a function of simplicity and complexity. Higher classes of ideas, such as "bad experiences with redeeming value," are considered to be complex because they are inclusive and tolerant of concepts that appear to be contradictory. In this way, the inclusive notion that "good can come from bad" is more complex than an exclusive idea such as "mistakes are simply bad; nothing good comes from them." As we stated in the previous chapter, vicious cycles are triggered when the wrong level is selected for problem solving. Another way to say this is that problems are initiated when the problem solver judges a difficult situation in a way that misses hidden complexities (i.e., is overly simplistic) or in a way that is overly complicated. An example of overcomplication might be family violence or sex abuse when problem solvers justify unacceptable behavior by finding redeeming value in it. In these types of situations there is a need for problem solvers to shift to a more simplistic understanding, such as that violence or certain types of sexual behavior are unjustifiable.

Another implication of the level chosen is the relationship between problem classification and action. Actions follow how the problem is understood. Unnecessary steps that start a pattern of problem avoidance or

overpursuit are initiated by the problem solver's understanding of the difficulty. As indicated previously, denial of the problem is similarly linked to the problem solver's understanding of the problem situation. This is the foundation of second-order change. By its very nature, second-order change is both simple and confusing. It may be defined only in context of what was there before it. It is a premise shift. It is a pattern shift. Therefore, it makes sense only in terms of the first-order premises and patterns of related solutions. A few more illustrations may help readers further understand the interesting nature of pattern shifts.

PUZZLES AND DILEMMAS

We are not retreating—we are advancing in another direction.

—Douglas MacArthur

The Finger Trap

One of the simplest examples of first- and second-order change is the "finger trap" toy that so many children have had fun with over the ages. The finger trap is a small cylinder made of woven hemp strips. The cylinder is not firm but flexible. One child asks another to put the index finger of each hand into each end and then try to escape these "handcuffs" by pulling her fingers out. As you might remember, simply pulling your fingers out only causes the fibers of the finger trap to bind more closely to your fingers. The more you pull, the tighter the finger trap becomes. It is only by giving up the logical solution of pulling out, and instead pushing in, that the trap finally releases and your fingers may be gently removed. Pushing in to get out is a second-order change.

A question can be raised about the logic that drives problem-solvers to try pulling out of the trap as a first-order solution. The instinct to pull out is universal; virtually all children initially try to solve the puzzle in this manner. Most children then get stuck in the cycle of trying this method over and over again. More careful consideration may shed some light on the hidden complexities of the finger trap and of second-order change.

In the process of development, children learn many fundamental lessons about life. An important lesson involves solving certain challenges in daily living by "pulling out" of them. If a child places her hand on an object that is too hot or too cold, she instinctively pulls her hand away. She learns to pull her feet out of her socks; the same procedure is used for taking off her shoes. If she steps in a mud puddle and her foot becomes stuck in the mud, she pulls her stuck foot out. When she grows older, she learns more complex variations on the same theme: To find your way after getting lost, you retrace your steps. In other words, you find your way out of a challenging situation by

going in the direction opposite from the way that you entered it. A child's mind thoroughly understands this rule. Upon seeing the finger trap for the first time, the child's mind immediately reads the problem, determines the problem-solving level, and goes into action. This process occurs so fast that it is almost instantaneous. There is only one problem: The finger trap represents an exception to the rule of pulling out. It cannot be solved that way.

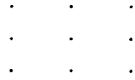
This is an elementary example of first- and second-order change. The logical solutions of pulling one's fingers directly out only further trap the fingers. The harder one pulls, the tighter the trap becomes. More of the same solution breeds more of the same results. This is the now familiar vicious cycle. The solution makes sense to the child, but it makes the problem worse. The resolution is a classic second-order change. The resolution is a reversal of the first-order solution. Pushing the fingers together releases the trap and allows the child to gently slide free. This resolution is based on viewing the dilemma differently. It is a product of using a different level of logic. The child solves the problem by doing less of the same instead of more of the same. The resolution is paradoxical and counterintuitive to most children. It usually results in cascades of laughter after discovering the "trick" of the trap. These elements are also typical of second-order change. First-order change appears logical to those trapped in the problem cycle and thus second-order change seems ironic, illogical, or even funny when viewed from the original position on the problem. The finger trap puzzle, although simple in form, has many profound ramifications. As mentioned earlier, avoidance or pulling away is a common mistake that sets up many complex human problems. Depression, anxiety disorders, chronic pain, and many other clinical conditions share this same fundamental error in logic.

The Old Nine-Dot Problem

At the risk of overkill, we ask you to engage in one more classic example of second-order change. These days the phrase "thinking outside of the box" is so often used that it has become almost trite. Yet we all continue to be trapped in our own logical boxes on a daily basis. The "nine-dot problem" has become almost as common. Solving it, however, even after having done so before, continues to trap us in our own assumptions and solutions. For those readers who are familiar with this problem, we ask you to stick with us for a moment. We will have some additional challenges for you. As a matter of fact, we have chosen to use this problem *because* so many readers will have encountered it before and will be sure that they will know the answers. This is the kind of confidence that leads to more problems.

In his popular book on creative problem solving titled *Conceptual Blockbusting: A Guide to Better Ideas*, James Adams (2001) follows the nine dot problem through several increasing challenges. Referring to the following dots, the basic directions to the problem are these:

Puzzle 1: Draw no more than FOUR straight lines (without lifting the pencil from the paper) that will cross through all nine dots.



This puzzle is extremely difficult to solve if you see the nine dots as a box that you cannot go outside of with your lines. For those attempting this puzzle for the first time, that is the key clue. Think outside the imaginary box!¹ However, before turning to the solution, or going smugly on if you know the solution, first try several more challenges with these dots.

Puzzle 2: Now draw no more than THREE straight lines (without lifting the pencil from the paper) that will cross through all nine dots.²

Got that one? OK. Now try this one:

Puzzle 3: Do the same with ONE straight line. (There are several solutions.)³

Finally, try this last challenge:

Puzzle 4: Do the same thing using ONE POINT. (Again, there are several possible solutions.)⁴

In each variation of this puzzle, the solution involves breaking a self-imposed set of logical assumptions. These assumptions are not intrinsic to the problem set out; they are something we impose on ourselves. Of course, once we accept these assumptions, they set implicit limits on the range and kind of possible solutions we can use. Breaking out of these self-imposed mental sets moves us to a new logical level with whole new realms of solutions open to us. What is more, these are solutions that seemed unimaginable or illogical before. The power of second-order change lies therein.

The nine-dot problem and its solutions also demonstrate the relative aspect of first-order and second-order change. First-order change, or what has been tried before, defines second-order change, or a solution that is outside of our current problem-solving assumptions. Once we reach outside of our assumptions and find a novel solution, the novel solution becomes part

¹The first puzzle is solved by drawing the first line across the top three dots and beyond them so the second line can be drawn through the third dot on the second row and through and beyond middle dot on the bottom row ending below the first column of dots. The third line is drawn straight up the first column. The fourth line is then drawn diagonally from top left to bottom right to connect the remaining dots. To solve the problem, our lines must go "outside the box."

²This challenge is solved by drawing three lines in a "W"-like formation, starting above and to the left of the top left dot. The first line goes diagonally through the left corner of the first column dot, the middle of the second dot in that column, and the right edge of the bottom dot in that column, to a point below the dots. The second line goes up the middle column in the same diagonal way to a point beyond that column to the right. The final line goes back down diagonally through the last column of dots.

³One solution is to use a line so far it covers all the dots as it goes across them. Another is to bend the paper into a cylinder and draw an angled line that goes continuously around the cylinder and through each row of lines as it passes around. There are other options as well.

⁴Folding or cutting the paper to stack the dots on top of each other allows one to stab a sharp point through them all at one time. There are other options here, too.

of a new set of assumptions. The new assumptions may again blind us from seeing other possibilities that might work as well or better in other similar situations. For now, the important point is that difficulties in problem solving are usually a function of our mind set. Mind-set problems are a naturally occurring phenomenon. As human beings, we all share the same susceptibility.

SECOND-ORDER CHANGE AT THE MACRO LEVEL

Although these puzzles present clear challenges, and they offer nice examples of first- and second-order change, they pose no urgency or threat to others or us if we don't solve them. Problems and life dilemmas offer no such luxury. Failure to resolve these situations may cause discomfort at the least, and real personal threat or loss of life at the worst. Because the stakes are higher, ignoring these dilemmas is much less of an option. Creative flexibility holds even higher risks. What if our solution doesn't work? What do we risk? Tried and true, less risky, and more conservative approaches feel like the safer and better choices. Furthermore, as these situations escalate, it becomes even harder to reverse our course or to choose another. These problems are not humorous. These are deadly serious dilemmas. That is why the following examples are so fascinating. The first two examples occur at larger social levels, and the third is a clinical intervention.

Vietnam War Demonstrations

Most readers will be familiar with the tragic killing of student protestors at Kent State University by National Guard troops during the Vietnam war. In retrospect, it appears to have been the product of a predictable set of logical yet escalating responses by both the student protestors and the Guardsmen. That is why it was so stunning when one of us witnessed the following during a massive antiwar demonstration at about the same time at a major midwestern university.

In the early 1970s, a small group of students stopped traffic by sitting down in the middle of Grand River Avenue in East Lansing, Michigan. This was in protest of President Nixon's bombing in Cambodia during the Vietnam war. Grand River Avenue is a major thoroughfare that runs past the campus of Michigan State University. It was not long before traffic was blocked for miles. The students in the street held up signs and chanted anti-war slogans. Upon arriving on the scene, the police ordered the crowd to disperse. This directive was ignored, and the students chanted more loudly and made abusive gestures toward the police. In response, the police called for reinforcements and shot tear gas into the crowd. The students refused to move, and the smell of tear gas brought out students from dormitories that were in the vicinity. They joined in with their fellow students, and in a short time the conditions for a major

riot were set. Police fired more tear gas, which brought out even more students. Soon hundreds of students were rushing toward the scene from every corner of the campus. Many were only curious, but others were willing to join in. They began throwing tear gas canisters back at the police. In response, the police called in a large contingent of state police dressed in full riot gear. As they stood in formation, their leader came out with a bullhorn. He loudly shouted to the crowd that a decision had been made to let the students peacefully demonstrate in the street. The police that were fighting with the crowd were directed to back down so that the students could demonstrate. The riot police retreated to an area that was outside of the view of the crowd.

In response, the crowd began to cheer. Once the cheering stopped, there was a pause, as it was unclear as to what should be done next. Some students went back to their dorms and brought back blankets, beer, guitars, and other things for a party. By 3 or 4 in the morning, most of the students had gone home. By 6:00 a.m., nearly all of the students were gone, and the police returned to kindly ask the remaining stragglers to clear the streets. This was done without further incident. The traffic pattern was reestablished, and police then lined the outside of the streets so that students could not return. Within another day, the situation was normal, without the need for police presence. It is clear that the response of the police was unexpected. The group of students who organized the protest was dependent on an overreaction from the police. Initially, the police did overreact, and this nearly helped to create a riot. The sudden reversal of the police position stopped the escalation and left the students with little else to do but have an all-night party on Grand River Avenue.

The Siege of Castle Hochosterwitz

Paul Watzlawick, John Weakland, and Richard Fisch (1974) offered the following historical account in the preface of their now-classic book, *Change*. Because these authors were some of the first to apply the ideas of first- and second-order change to clinical problems and their resolution, we have chosen to recount one of the wonderful examples they used to begin their book.

When in 1334 the Duchess of Tyrol, Margareta Maultasch, encircled the castle of Hochosterwitz in the province of Carinthia, she knew only too well that the fortress, situated on an incredibly steep rock rising high above the valley floor, was impregnable to direct attack and would yield only to a long siege. In due course, the situation of the defenders became critical: they were down to their last ox and had only two bags of barley corn left. Margareta's situation was becoming equally pressing, albeit for different reasons: her troops were beginning to be unruly, there seemed to be no end to the siege in sight, and she had similarly urgent military business elsewhere. At this point the commandant of the castle decided

on a desperate course of action which to his men must have seemed sheer folly: he had the last ox slaughtered, had its abdominal cavity filled with the remaining barley, and ordered the carcass thrown down the steep cliff onto the meadow in front of the enemy camp. Upon receiving this scornful message from above, the discouraged duchess abandoned the siege and moved on. (p. xi)

The AWOL Patient

Another of us came upon the following situation in the hospital where he worked.

Just before I arrived on the scene, a patient had just burst through the doors of the locked psychiatric ward and was headed for the elevator or stairs to go AWOL, or absent without official leave from the unit. He was extremely agitated and pacing. He threatened to jump over the stairwell and injure or kill himself if the staff came any closer. The unit staff, hot on his heels, were pleading and demanding that he come back to the unit and stay back from the stairs. He met this with louder and angrier threats and demands that he leave. The situation was dangerous and escalating.

Stepping into the situation, I asked him what was going on. Startled, he said he was going and that nobody was going to stop him. Pacing with him now, I agreed that obviously no one understood his position. I said how I hated that kind of thing. Asking him to explain more to me so I could advocate for him, he told me what was happening. Agreeing with his position and frustration, I sat down with him on a bench in the vestibule. We agreed to go over the head of the staff on hand. We returned to the unit to have a direct discussion with the physician in charge of the unit. From there we negotiated a resolution to the patient's dilemma. After he thanked the psychiatrist and me, we filled in the staff on the resolution.

Each dilemma was an escalating or desperate situation. The attempted solutions only made things worse. On the university campus, the more the police tried to control or disperse the protestors, the larger and angrier the crowd grew. At the castle siege, both armies were getting desperate and frustrated. There seemed no end to the stalemate. For the psychiatric staff, the more they attempted to restrain or control their patient, the more agitated and dangerous he became. The resolution to each dilemma embodied a second-order change. When the police said they would allow the students to peacefully protest, there was nothing to fuel further escalation. The police reversed their solutions from preventing protest to acknowledging and allowing it. They achieved their goals of avoiding harm and dispersing the crowd by not pursuing them directly. The protest ended peacefully the next morning. The occupants of the castle under siege, faced with eventual starvation or sudden salvation, were freed by throwing their last food to their enemies. This solution

was the opposite of what anyone would expect from a besieged and starving garrison. Discouraged, the enemy left. When the angry patient found an advocate and not an adversary, he not only calmed down but also reversed his path and returned to the unit. A therapeutic alliance was achieved through unexpected validation instead of direct opposition. Not all second-order change is this dramatic, but it does share similar qualities.

Although first-order change does often resolve perceived difficulties, true impasses and problems result from repeated ineffective first-order solutions. The impasse of the castle siege, the potential for the police to fire on the protestors, and the agitated and dangerous patient were all products of escalating first-order solutions. The second-order resolution in each situation was a reversal that changed the nature of the situation and opened a whole new set of possible paths toward resolution.

SECOND-ORDER CHANGE IN PSYCHOTHERAPY

We have shown how dilemmas in these puzzles relate to human dilemmas. Yet how do the solutions relate to the resolution of clinical problems? In other words, what is the relationship between the solutions found in our stories and puzzles with effective psychotherapy? Exactly how, one might ask, are these concepts applied to effective psychotherapy, and how do effective psychotherapists bring them about?

The first answer lies in one of the basic tenets of the theory of logical types and second-order change; that is, second-order change may be understood only in relationship to first-order change. Therefore, again paraphrasing the words of John Weakland, it is critical to define what is the "same damned thing over and over again" (personal communication, October 30, 1980) before we can understand and initiate something different. From this perspective, therapists must first know the pattern of the problem before they can initiate a pattern shift. Without such knowledge, a therapist or any other helper runs the risk of being drawn into the same logical yet self-defeating solutions as all others involved in the problem. One source of this knowledge is the psychotherapy and psychopathology literature about the problem in question. Although it may be broad-reaching and varied, this literature may converge on several typical patterns for the problem and dilemmas for therapists. The simplest and truest questions, however, are the following: How is the problem being *defined* by all parties involved in it? *Who* is involved with the problem? What language, concepts, and assumptions are being used to define it? *How* is it a problem for the involved parties? What has been done about the problem by all involved? What has been done in similar situations? How has that worked? What are some *examples* of how the problem occurs, and how it is being struggled with? What are the *strengths* of those involved? What is *working*? What is going on when the problem isn't happening? What

are the clients' ethnic, sociocultural and religious traditions, economic situation, gender, sexual preference, and so on, and how do these interact with those of the therapist? What is the *goal* of the involved parties?

These are only a few simple questions, among others, that help an intervener get an idea of the pattern of the problem and how he or she might interact with it. These questions are not rocket science, but they do get to the heart of first-order patterns. As we shall see in future chapters, many effective therapies pose these questions in very different ways.

Turning to how effective therapists facilitate second-order change from this perspective, these are but a few options:

- The first point to remember is that second-order change may begin with a shift in the relationship of the therapist with the client(s) involved. This shift may itself represent a second-order change for the client, or it may be a precursor for it to follow.
- Therapists may facilitate changes in a client's assumptions, frames, or premises.
- They may also block, reverse, or redirect first-order solutions.
- They may prescribe the formerly problematic interactions for therapeutic purposes.
- Finally, they will look for and support new assumptions and solution patterns and reinforce and amplify them as they are found or initiated.

This is a short list that sounds too simple. Admittedly, it is not complete, but these actions form a core of what effective therapists do from this view when fostering second-order change from different perspectives. They will be described in more detail in a subsequent section.

Premises and Corollaries

Recall from the last chapter that this model is based on the three common errors that set vicious cycles in motion:

1. *Unnecessary actions are taken to solve a problem.* Unnecessary actions are actions that move the problem-solver in a direction that goes away from the problem or in a direction that overpursues the problem. Movement away from the problem includes avoidance or other means of escape that involve attempts to rationalize the problem away or disqualify the problem. Movements that go too close to the problem involve efforts that are designed to make the problem go away by force or make something happen that can only occur more naturally.

2. *Not taking actions that are necessary.* This involves lack of action or failure to attend to situations that are becoming increasingly problematic.
3. *Efforts to solve the problem occur at the wrong level.* This involves the way that the problem solver understands the problem. Vicious cycles occur when problem solvers read too much into the problem or not enough. Reading too much into a problem can result in problem solvers creating new problems that must be solved as a prerequisite for solving the problem at hand, missing solutions that have occurred, or turning normal ups and downs of daily living into psychological disturbances. For example, some understandings are so complex as to create additional problems than the problem at hand. Asking the question "why" when solving a behavioral concern creates an additional problem of trying to understand the complex nature of human motivation as a prerequisite for solving the problem. This takes a problem that is already difficult and makes it far more difficult, if not impossible, to solve. Overly complex understandings may also cause the problem-solver to miss solutions when they occur. The parent who wants his child to "want to study" may miss the progress involved when the child complies with studying, especially if the child does not study with a big smile on her face. Making a problem overly complex can result in efforts to fix problems that are best left alone. In marriage, arguments that are designed to change the personality of one's partner rarely work. Although reading too much into a problem is a kick-point for vicious cycles, so is not reading enough into the problem. Oversimplifying a problem tends to trivialize the problem and its solution. Trivializing the problem ultimately dishonors the problem-solver and the difficulties of change. In response, the problem bearer may become embroiled in attempts to demonstrate that the problem is much more difficult than how it has been characterized.

Operationalizing Second-Order Change

Second-order change can be operationalized in the following ways for therapists. The phrase "something to do with" is used out of respect for the many ways that exist for bringing about second-order change. Because change is so complex, many of these elements may be observed in any given case.

- If the first-order solution is to *go away from the problem*, then the second-order solution will have something to do with *going toward it*.

- If the first-order solution is to *overpursue the problem*, then the second-order solution will have something to do with *stopping and reversing the pursuit*.
- If the first-order solution is to *not attend to the problem*, then the second-order solution will involve *acknowledging the problem and taking necessary problem-solving action*.
- If the first-order solution involves *making the problem overly complex*, then the second-order solution will involve *simplifying the problem and narrowing problem-solving efforts* down to the problem at hand and clarifying the problem's parameters.
- If the first-order solution is to *overintervene* with normal ups and downs of daily living, then second-order solutions will involve *tolerating and accepting* the amount of unpleasantness that is a natural part of the human condition.
- If the first-order solution *reads too little into the difficulty*, or *simplifies the problem so much as to trivialize it*, then the second-order solution will *honor the complexity of the problem*. To honor complexity entails both respecting and assisting the problem solver with building an understanding that clarifies the problem and its parameters in a way that is understood by the problem solver.

Once more, these options may appear overly simple right now. However, they will apply to the wide complexity of problems and their effective psychotherapies that we review in the chapters ahead. All of these positions and interventions will occur within the broad context of what Frank and Frank (1991) termed a *contextual model*, which we mentioned in chapter 1 of this volume. We discuss this contextual model in the next two chapters. For now, it may be helpful to look in more detail at a clinical example to bring these ideas into better clinical focus.

Revisiting the Effective Interventions

More light may be shed on this perspective by revisiting one of the therapy interventions that began this chapter. Recall the first therapist, who was working with a client who has panic attacks. She asked her client to bring on panic during the session. Exploring the kind of thinking that supports this intervention will help the ideas of first- and second-order change come to life clinically. This discussion will also offer a head start, or a brief glimpse of how we discuss effective interventions in anxiety in the first chapter of the next part of this book, "Following the Thread: Empirically Supported Therapies."

The ideas of first- and second-order change can be seen in the classic problem of panic attacks and their solution. Panic attacks often begin by some chance occurrence that causes us to react with symptoms of anxiety. The initial kick-point for the first attack can be almost anything that causes

us to feel widely out of control, unsure if we can handle the situation, and worried that the situation is dangerous. Innate fight-or-flight mechanisms set in. These include such things as increasing heart rate; the blood moving to the center of our body and making our hands and feet tingle and feel numb; rapid, shallow breathing; hypervigilance and increased scanning of our surroundings; and rapid thoughts. Shallow and rapid breathing may also cause us to feel dizzy and faint and to have chest pains. These responses have been adaptive for our species over the ages, enabling us to prepare to fight off danger or to flee from it. They can also be terrifying in themselves.

If we are aware of the cause of our panic, and the innate nature of these physiological responses, then we may be able to categorize our reaction as unpleasant but natural. In so doing, we can often move beyond the incident. We might act directly on the situation that made us anxious. We might learn new skills to master it. We might decide that we misinterpreted the situation, or find that our view was correct yet there was nothing to worry about. In these instances, we will move beyond the incident with few, if any, residual effects.

However, we may become very alarmed and worried about the panic attack itself. How did we get that out of control? What happened to us? Is there something physically wrong? Are we having heart problems? How can we avoid ever having that happen again? We get anxious about having gotten anxious. This can be the inception of a vicious cycle. Our resulting solutions *become* the very things that produce the syndrome of escalating anxiety and ongoing recurrent panic attacks. Our solutions exacerbate the anxiety we seek to quell. Our solutions become the problem. This is a prime example of first-order change.

This description is more than hypothetical; it represents a general theme that characterizes most cases of panic. Clients attempt to master their anxiety by avoiding it. They become anxious about becoming anxious. At a more specific level, the process includes many predictable elements. Clients try to avoid anxiety-provoking situations at any cost. They become hypervigilant for any body sign of anxiety, such as shallower or more rapid breathing, sweaty palms, rapid speech, racing thoughts, and so on. What is more, they try to control any sign of these things at the first sign of any of them. The irony of these solutions is that this intense focus only heightens their anxiety. Heightened anxiety can kick in the automatic physiological response cycle that they are trying to avoid. These anxiety reactions then make clients feel more out of control and panicked. They begin catastrophizing their situation. They experience tunnel vision in their focus and black-and-white, all-or-nothing thinking: "I either need to escape or I'm going to die!"; "I must calm down!"; "I'm having a heart attack!" A self-fulfilling prophecy sets in, and they are well on their way to their next panic attack. Their solutions have become the problem. This is first-order change. It is often a vicious cycle of self-defeating behavior.

It is interesting that all empirically supported solutions to such panic attack problems involve blocking or reversing client solutions. You do not master anxiety by avoiding it. You master it by going toward it. It's not the panic that is the problem. It's the way the client is going about resolving it.

SECOND-ORDER STRATEGIES

Strategies that block or reverse failed solutions to difficulties change the class of solutions that are being used in problem solving. Class shift is a catalyst in the change process. In our panic example, the client fell into a trap in which all attempts at symptom resolution fit into a predictable pattern. The pattern may be labeled as *the class of all overreactions*. In effect, the client is overreacting to unpleasant internal experiences. The client's overreactions have a theme that involves attempts to flee from the symptoms. The therapeutic objective becomes one of stopping the overreaction pattern. Either blocking or reversing flight attempts accomplishes this.

Blocking and Acceptance

Blocking strategies are defined as approaches designed to stop solutions that are failing to solve a problem. Blocking and acceptance strategies are found in a number of different ESTs. An example is psychoeducational approaches in which acceptance is embedded in the educational framework. Clients are educated about the psychobiology of panic and how it works. The process is natural. The client may have mistaken their reactions for something else, but there is nothing to resolve. This is an acceptance strategy. For some clients, this is enough to help them relax. They don't need to use their solutions. Their panic goes away. Blocking also can take the form of engaging in behaviors that are mutually exclusive from the solution pattern. Mutually exclusive behaviors stop attempts to solve the problem by getting the problem solver involved with doing something else. Clients may be asked to identify situations that bring on different levels of anxiety and scale them. They are to locate exactly where their body begins to respond, and how the response occurs, and scale this. They are to keep thought records and note the kinds of thoughts that they are having when they become anxious. They are then asked to examine how true these thoughts and fears might be. Paying attention and scaling symptoms are actions that are mutually exclusive from escape. In following the assignment, the problem solver must stay with the symptom to accomplish the task that has been assigned. Staying with the symptom is a subtle way of going toward it.

Reversals

Reversals are defined as approaches that are designed to help the client use solutions that are counter or opposite to the solutions that are being used

to solve the problem. Because avoidance is the theme with our panic-stricken client, the opposite would be strategies that direct the client to go toward her symptom. A reversal for panic might entail asking a client to imagine successively more anxiety-provoking situations while maintaining relaxation. Clients may be offered a "be spontaneous" paradox. This entails asking the client to experience anxiety and the sensation of being out of control, in a controlled and deliberate way.

Panic symptoms are notorious for occurring spontaneously—they seem to come out of the blue. The problem solver has the experience that she is unable to control her mind. Asking the client to deliberately engage in the symptom is inviting her to perform a naturally occurring experience on purpose. Doing something willfully is the opposite of having it occur involuntarily. This reverses the cycle. Instead of having panic attacks involuntarily, the problem solver is now trying to have panic attacks on purpose. Whatever anxiety she can conjure up will be more manageable because she has made it happen by her own choosing. This shift reestablishes the problem solver's confidence in her ability to control herself.

Invariably, in each empirically supported approach to panic a context is created in which clients must go toward the symptom. Mastery is gained through the process. The therapist treating a client with panic symptoms, described at the start of the chapter, used a reversal. The reversal was embedded in the request for the client to bring on anxiety in the session, in service of the treatment goals that had been previously established. Each intervention example described at the start of this chapter represents an attempt to interdict or reverse problematic client solutions. The theoretical rationales that support these interventions vary widely. They implicitly share, however, the common target of intentionally or unintentionally producing second-order change. We intend to explore each separate kind of intervention in successive chapters.

Before moving on, it might be helpful to briefly describe a list of other interventions that come from the perspective of interdicting first-order vicious cycles and initiating second-order change. These interventions are associated with intentional efforts to produce second-order change. Understanding how these interventions work will be helpful for seeing the common thread that runs through all effective therapies.

Restraining Change

Restraining clients from moving too quickly, or prohibiting them from directly attempting to achieve their desired goal, often produces a second-order shift. This is accomplished through the use of *soft restraints*, such as giving the client a directive to go slowly toward his or her goal, and *hard restraints*, which involve either prohibiting a goal-oriented action or offering challenges to clients. A very subtle version of a soft restraint is simply the

absence of a directive to change. An example of this might involve a therapist giving a client the homework assignment of thinking about what changes he might want to make in therapy. This assignment does not contain a message that directs the client to change the problem. A harder restraint might involve the therapist giving a prohibition against changing or directly working on the problem. The client might be told that the problem is too complicated and must be understood more completely before he or she even thinks about taking actions. Restraining techniques are based on the rationale that problem solvers often engage in too much self-pressure around change. Pressuring oneself to change builds up strong internal resistance that enhances the likelihood of making errors in the change process. Also, as stated earlier, clients seek therapy because they want to change. The expectation is that the therapist is an agent of change. Psychotherapy is, in essence, a powerful change context. Restraining the problem solver from change takes the pressure of changing the problem off and is a reversal at the psychotherapy context level.

Normalizing

The intervention of normalizing attempts to put clients at greater ease by contextualizing their difficulties as normal reactions, given the constraints of their situations. This is another variant of a position of acceptance. Because it allows clients to relax their self-pressured efforts to solve a perceived difficulty, normalizing helps them depathologize themselves and whatever they are struggling with. With normalization, the therapist does not deny that the client is feeling or acting badly; instead, the client is told that acting or feeling badly is expected under the circumstances. To emphasize this point the therapist might indicate that it is surprising that the client isn't functioning even worse given the set of circumstances that she is facing. The client might be given outside readings, psychoeducation, or direct explanations about her condition to further illustrate this point. Reversing the perception of being abnormal can result in a second-order shift.

Framing, Reframing, and Deframing

Framing involves placing a person, situation, action, or problem in a particular context. An important aspect of the psychotherapy process is framing or describing the problem(s) that will be worked on. We discuss this further in the next chapter. From the perspective of second-order change, problem solvers often come for therapy in a state of demoralization. Their problem-solving efforts have gone awry. They may feel exhausted and thoroughly befuddled. Hope for solving the problem is quickly being lost. When the therapist listens to the concerns a problem solver and feeds them back in a way that helps the client make sense of what is wrong, loss of hope is re-

versed. Taking a problem that is confusing or that defies description and defining it in such a way that opportunities for change are apparent is a reversal of the problem at the problem description level. In some cases, this is enough of a reversal to support second-order change.

Reframing is the formal name for a class of interventions that involve shifts in the classification of meanings. This type of intervention involves putting a person, situation, action, or problem in an alternate but equally sensible and more useful context. (This was discussed previously in this chapter in the section titled "The Theory of Logical Types.") Therapists, to create rationales for making second-order shifts in the problem-solving process, use reframing. Good reframes make such shifts seem reasonable. Reframes may be given along with a directive to do something that is contrary to current problem-solving efforts. A reframe may also be given without specifically directing the problem solver to take action. In these situations, action is implied. In a previous example, a therapist reframed social mistakes by stressing the necessity of making such mistakes to enhance social learning. The therapist could have used this new construct as a rationale for suggesting that the client deliberately make social mistakes as part of a homework assignment. However, the therapist could have given the reframe and asked the client to think about it. In the former example, action on the basis of the new construct is explicit. In the latter example, new action is implicit, because the logic of the reframe suggests that solutions are opposite of what they seem. Well-formed reframes reverse constructs that support problems and are used to create new or different problem-solving efforts.

Deframing may be understood as a class of interventions that is opposite of reframing. Whereas reframing creates new mental constructs by adding levels, deframing reduces levels or separates classes that have been mixed in ways that are unhelpful to the problem solver. The process of deframing involves deconstruction of the context of a particular frame of reference to eliminate it as the cause of a problem, challenge its absolute reality base, or simply point out that it is a point of view. For example, pharmaceutical companies have had a powerful effect on consumers of mental health services. It is common for persons with serious behavioral disorders such as bipolar disorder to refer to themselves as having brain chemical imbalances. On one hand, this has reduced stigma about taking medicine, but on the other hand, this view has also created new problems. Consider a problem solver with bipolar disorder who has adopted the brain imbalance theory and now relates all shifts in mood, no matter how insignificant, to brain chemistry. Because medicine is what balances the chemistry of the brain, it becomes reasonable to assume that any perturbation in mood requires chemical adjustment. This sort of approach may well trigger a cycle of visits to the doctor for increases and shifts in medication. This problem can be further complicated by the fact that the medicines used to treat bipolar disorder can have unpleasant effects and feed into the cycle. In the end, the problem solver may end up

taking multiple medications at very high dosage levels. The objective of therapy in such situations is to deframe chemical imbalance theory. This might be done by having the problem solver begin to think about the possibility that some changes in mood may be normal fluctuations or expected responses that anyone might have to certain stresses. The intent of the process is to separate behavior that is "bipolar" and in need of medicine from behavior that might be best classified another way. Over time, the elements in the bipolar category are significantly reduced. Because reducing the category is opposite to growing, this represents a second-order change.

Positioning

Positioning involves taking positions relative to problem solvers that are designed to facilitate change. We discuss therapeutic positioning in more detail in the next chapter, because it is inextricably linked with the therapeutic alliance. Therapist positions may include "cautious optimism;" "a one-down position;" "strategic pessimism;" or another position that is counter to the expectation of the client. Here again, the psychotherapy change context comes with certain expectations for how the therapist should behave. Reversals at this level can be sufficient for the problem solver make significant changes in the problem that has stimulated the need for therapy.

Prescribing Symptoms

We discussed prescribing symptoms earlier in the chapter as relates to panic attacks. It has a much broader usage in psychotherapy practice, although the rationale is similar to those for other problems. Symptom prescription involves asking clients to engage purposefully in some variation of the described problem behaviors. There are generally two types of situations in which prescribing the symptom is used. The first is when a symptom or problem behavior is experienced as automatic or "just happening." Such prescriptions make the problem pattern less automatic and put it more in the client's control. The second type of situation in which symptom prescriptions are used involves problem solvers who have difficulty forming cooperative relationships with therapists or others. Some problem solvers are extremely threatened about submitting to the authority of others and behave defiantly in an effort to protect their right to self-determination. In such cases, carefully constructed symptom prescriptions can provide the client with a face-saving way of changing a problem pattern. The problem solver improves by defying the therapist. This use of symptom prescriptions occurs at the therapeutic alliance level of psychotherapy and reverses the clients efforts to be uncooperative.

Predicting or Prescribing Difficulties or Relapses

Predicting or prescribing difficulties or relapses is a class of interventions used to deflect problem solvers from being discouraged by perceived setbacks or to consolidate gains by reencountering old perceived dangers. For example, clients might be warned that first efforts to bring about change might not work as well as expected and that the problem may actually worsen a bit before improvement occurs. Once the problem begins to show improvement, the therapist might normalize the possibility of relapse, discuss relapse prevention strategies, or even prescribe a relapse so that relapse prevention can be practiced. The sense of relief about making significant changes in a problem can lead to self-pressure in an effort to keep the problem from occurring again. This can lead to a relapse. Relapse prevention strategies are designed to reverse this pressure and reduce the likelihood or severity of a relapse.

Adopting a Goal-Oriented Future Position

When clients come for therapy, they are under the influence of their problems. They are locked into a present-past orientation, meaning that they can see the problem from present to past and from past to present. In their demoralized state, they cannot see beyond the problem to the future, when their situation will be better. The state of "better" may not be conceivable to them. An important process in psychotherapy is that of establishing goals. We discuss this further in the next chapter. The process of establishing goals involves a reversal from present-past to the future and describes the hoped-for condition. This reversal represents another type of second-order change that is inextricably tied to the therapeutic alliance. It is sometimes a sufficient shift to support change.

THE SECRET IS OUT

A partial sampling of quotes from some of the researchers and founders of several ESTs suggests a growing appreciation for the concepts of first- and second-order change. As reflected in their own words, even these widely known authors are beginning to recognize the common thread that runs through their approaches.

The first approaches represent interventions for couple's problems. Neil Jacobson, Andy Christensen, and John Gottman recently developed ESTs for marital issues, to be discussed in chapter 10 of this volume. The first of these was Jacobson and Christensen (1996). Referring to couple problems, they said,

As Paul Watzlawick, John Weakland, Richard Fisch, and others have been telling us since 1967, there are times when efforts to change one's partner actually have the opposite effect. Direct attempts to change an intimate partner are often self-defeating, both because the particular efforts are misguided and because such attempts are likely to have the opposite effect. (1974, p. 13)

Another force in ESTs for couples therapy is John Gottman, who had this to say about couple's problems:

I contend that the current emphasis in marital therapy on problem-solving is greatly misplaced . . . 69% of the time [couples] were talking about a perpetual problem . . . instead of *solving* these perpetual problems, what seems to be important is whether or not a couple can establish a *dialogue* with their perpetual problems . . . if they cannot, the conflict becomes gridlocked. . . . Our findings suggest that people, including therapists, need to change their expectations about solving fundamental problems in an intimate relationship . . . I think that the goal of most therapy around problem-solving ought to be to help the couple move from gridlocked conflict with a perpetual problem to a dialogue with the perpetual problem. (Gottman, 1999, p. 56)

These evidence-supported approaches to couples treatment are based in large part on interdicting ongoing and fruitless solutions that are applied between couples. They seek to disengage couples from problematic change attempts and to reengage them at another level to more effectively change their problems.

In a more recent example of an empirically supported approach to relapse prevention in depression, to be discussed in chapter 8, Zindel Segal, Mark Williams, and John Teasdale (2002) struck upon a similar idea. Referring to their mindfulness-based stress reduction approach (MBSR), they noted,

Instructors in MBSR encouraged participants to let go of the idea that problems might, with enough effort, be "fixed." If fixing worked, then fine. But the mindfulness approach was explicit about the danger that such attempts at fixing might merely reinforce people's attitude that their problems were the "enemy," and that once they were eliminated, then everything would be fine. The problem is that this approach may encourage further attempts to solve problems by ruminating on them, and these attempts often keep people trapped in the state from which they are trying to escape. This is something that family therapists have emphasized for years. (Watzlawick et al., 1974, p. 60)

FOLLOWING THE THREAD

Second-order change is being recognized, if not by the term, then by the concept, across a wide range of effective psychotherapies. We follow this

thread through the six chapters of the next part of this volume. First, however, we must return to the polemic debate introduced in the first chapter. These interventions are approaches of the best-practices camp described earlier. Recall that there is equally compelling evidence that all of these ESTs are essentially similar in their effects. The common-factors camp reminds us that the therapeutic relationship, working alliance, and other general commonly therapeutic factors account for much more influence on positive outcome in the literature than do specific techniques. How can this be accounted for from the perspective of first- and second-order change? In the next chapter, we offer some answers.